TENNESSEE

Disaster Mental Health Response

2012

Acknowledgements

The State of Tennessee Disaster Mental Health Response Plan was developed by individuals from the

- American Red Cross,
- Centerstone of Tennessee,
- Mental Health Cooperative,
- Metro Public Health Department,
- Tennessee Association of Mental Health Organizations,
- Tennessee Department of Health,
- Tennessee Department of Mental Health,
- Tennessee Emergency Management Agency, and
- Volunteer Behavioral Health Care System.

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- Kandy Templeton, Volunteer Behavioral Health Care System, and,
- Angie Thompson, Metro Public Health Department.

Information included in this document on Psychological First Aid was provided by the Psychological First Aid: Field Operations Guide, 2nd Edition (National Child Traumatic Stress Network, and National Center for PTSD)

Information included in this document on the Crisis Counseling Program, Immediate Services Program, and Regular Services Program was provided by the Federal Emergency Management Agency

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Tennessee Disaster Mental Health Response

Revised annually in January

First edition dated and distributed January 2012

Table of Contents


DISASTER
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Mission Statement

The mission of the State of Tennessee Disaster Mental Health Response Plan and State/Regional Committees is to facilitate coordinated state, regional, and local mental health planning, intervention, and response efforts relative to disasters of any type in order to maintain quality care, safety, and security for survivors, their families, disaster responders, and volunteers.

Organizational Structure and Roles

State of Tennessee Disaster Mental Health Response Committee

The State of Tennessee Disaster Mental Health Response Committee shall be comprised of a representative from the Tennessee Emergency Management Agency (TEMA), Tennessee Department of Mental Health (TDMH), Tennessee Department of Health (TDH), one county Emergency Management Agency (EMA), each of the six Regional Disaster Mental Health Response Committees, and State Level American Red Cross (ARC). The committee members shall elect a committee chair who will serve for a term of two years. The committee will meet quarterly with at least one meeting per year occurring in person. The committee shall specify the organizational and operational goals for Tennessee's mental health response to all large scale or significant disasters and shall provide overall policy direction for the program. The committee shall be responsible for:

1) Program development, planning, and evaluation;
2) Coordination of program activities and disaster mental health response;
3) Providing a mechanism for quality assurance which includes required credentials for disaster mental health responders;
4) Identifying disaster response regions;
5) Developing response standards;
6) Arranging for and supporting training of disaster mental health responders; and
7) Providing consultation to regional disaster mental health response teams.
8) Annual review and updates to plan

* *This plan does not supersede any current Disaster Mental Health Plans that are active in a participating agency, region or area of the state.*

Regional Disaster Mental Health Response Committees

Six (6) Regional Disaster Mental Health Response Committees (Northeast, Knox, Southeast, Middle, West, and Shelby) shall be comprised of a representative from the Tennessee Department of Health, local Emergency Management Agencies (EMA), local Health Department's Public Health Emergency Response (PHEP) Team, all Directors of Community Mental Health Crisis Service in that area, and local ARC. Representatives from other local mental health entities and associations with resources to assist with mental health needs around disaster response will be invited to serve on this committee. The committee members shall elect a committee chair who will serve for a term of two years. The Regional Disaster Mental Health Response Committee shall be responsible for the implementation and coordination of the program in their region according to the specifications developed by the State Committee. The Regional Disaster Mental Health Response Committee will maintain a list of Disaster Mental Health Response Teams who serve their region and via mutual aid serve other state regions as requested.

The Role of Participating Agencies

Tennessee Emergency Management Agency (TEMA)

TEMA is the lead state agency to coordinate and direct disaster mental health response services to manage large scale natural, technological, or other human-made disasters and other major emergencies which might affect the lives, health, mental health, and welfare of the citizens of Tennessee.

Tennessee Department of Mental Health (TDMH)

TDMH is the state agency which assists TEMA in coordinating and directing disaster mental health response services to manage large scale natural, technological, or other human-made disasters and other major emergencies which might affect the lives, health, mental health, and welfare of the citizens of Tennessee.

Tennessee Department of Health (TDH) and Regional/Local County Health Departments

TDH is the state agency which assists TEMA in coordinating and directing public health and is assigned the duty of coordinating medical services, including disaster mental health services, to victims of disaster, and sheltering individuals with special medical and/or mental health needs.

County Emergency Management Agency (EMA)

EMA is the lead county agency to coordinate and direct disaster mental health response services to manage large scale natural, technological, or other human-made disasters and other major emergencies which might affect the lives, health, mental health, and welfare of the citizens in that county.

Community Mental Health Crisis Services (CMHC)

Community Mental Health providers shall maintain a roster of mental health professionals specifically trained in disaster mental health response who will be available when requested by any agency of the state or ARC. These providers will operate within the framework of an authorized disaster response system and shall remain within the scope of their expertise and designated role. For example, theses responders shall:

- **a.** Enhance immediate safety, and provide emotional comfort.
- **b.** Establish a human connection in a non-intrusive and compassionate manner.
- **c.** Calm and orient emotionally overwhelmed or distraught survivors.
- **d.** Connect survivors as soon as possible to social support networks, including family members, friends, neighbors, and community helping resources.
- **e.** Support positive coping, acknowledge coping efforts and strengths, and empower survivors.
- **f.** Provide information that may help survivors to cope effectively with the psychological impact of disasters.
- **g.** Refer those survivors who require more intensive mental health support to appropriate mental health services.
- **h.** Provide Psychological First Aid to emergency responders.

American Red Cross (ARC)

Congress mandates the role of ARC in times of disaster that it has neither the authority nor the right to surrender. A statement of understanding exists between the ARC and the Federal Emergency Management Agency (FEMA) that

states ARC will provide disaster related mental health assistance in a shelter setting or at the scene of a disaster or in the immediate aftermath of a disaster, including assessment of mental health status and needs, stress reduction, brief counseling, crisis intervention, referral, and follow-up recommendations. The ARC utilizes a three-element intervention strategy that includes: 1) triage and mental health surveillance using PsySTART; 2) promotion of resilience & coping skills; and, 3) timely interventions to mitigate psychological complications of disaster. The responsibility for more intensive or long-term care will rest with public or private sector mental health resources. The ARC DMH State Advisor has a responsibility for capacity building, increasing chapter readiness, and collaborating with partners in order to prepare for the mental health implications of disaster and improve readiness to respond to the mental health needs and challenges of a disaster across the state. ARC Disaster Mental Health Volunteers shall:

a. Enhance immediate safety, and provide emotional comfort.

b. Establish a human connection in a non-intrusive and compassionate manner.

c. Calm and orient emotionally overwhelmed or distraught survivors.

d. Connect survivors as soon as possible to social support networks, including family members, friends, neighbors, and community helping resources.

e. Support positive coping, acknowledge coping efforts and strengths, and empower survivors.

f. Provide information that may help survivors to cope effectively with the psychological impact of disasters.

g. Refer those survivors who require more intensive mental health support to appropriate mental health services.

h. Provide Psychological First Aid to survivors and other workers.

i. Work with staff to reduce stress on operations and mitigate adverse outcomes.

Terminology/Definitions

Critical Incident/Traumatic Event – Critical incidents and traumatic events are considered any event powerful enough to cause significant distress for those involved. In particular, this includes events that threaten the safety or life of rescue personnel and/or victims/survivors. Some of the events involve small groups of people impacted by an event who will benefit from crisis intervention. Other events are on a mass scale and include natural disasters, mass casualties, human-made accidental events or human-made intentional events.

Natural Disaster – Natural disasters include weather-related phenomena such as floods, tornadoes, hurricanes, earthquakes, and other climatic extremes that often impact large numbers of the general public. These disasters often create the need for emergency shelters and involve prolonged discomfort and substantial social and economic upheaval for communities.

Human-Made/Accidental Traumatic Events – Accidental disasters that impact large numbers of peoples and create environmental hazards such as a plane crash, bus accident, train wreck, explosion, or hazardous material spill.

Human-Made/Intentional Traumatic Events – Disasters involving criminal intent, which may include shootings, bombings, etc., creating situations for mass panic and possibly mass casualty.

Assessment – The professional determination of mental healthcare needs following a disaster or critical incident to determine the perceived scope of mental health interventions.

Operations

Post Event Assessment of Mental Health Need

Prior to the activation of a disaster mental health response, there must be a local assessment of mental health need for community members as well as emergency service responders. For large scale disasters, ARC will conduct the initial needs assessment utilizing PsySTART which is the mental health surveillance strategy that ARC utilizes to determine the scope of the response in the impacted area and will share this information with the Regional Disaster Mental Health Committee for the coordination of a response. As some events/situations do not activate an ARC response, in those cases the local Emergency Management Agency (EMA) in the impacted area(s) will request the local Department of Health and/or Community Mental Health Center conduct the initial needs assessment.

For disasters where a local Emergency Operations Center (EOC) is activated a representative from ARC and a mental health representative from the local Health Department or the local CMHC will be located in the EOC for disaster mental health issues. If it is a multi-county disaster, the state EOC will also be activated. When the state EOC is activated, ARC and TDMH will have its designee represented in the EOC to address disaster mental health needs.

Disaster Mental Health Response Personnel

All ARC chapters will maintain a list of Disaster Mental Health Volunteers who they can activate in their area. These mental health professionals must possess an unencumbered, independent mental health license. Volunteers serving on behalf of ARC will be considered ARC Disaster Mental Health Volunteers and will be entered into the ARC staffing system. ARC will contact the Regional Disaster Mental Health Committee for additional disaster mental health resources if the need exceeds ARC capabilities.

Regional Disaster Mental Health Committees will maintain a list of all active Disaster Mental Health Response Teams in their area. There are various agencies/entities in the state that have teams of trained individuals. Some teams are comprised of mental health professionals only (Bachelors, Master, and Doctorate degrees in a mental health related field), and some are industry specific peer teams with a mental health professional(s). Any entity may contact the Regional Disaster Mental Health Committee to request disaster mental health resources.

Credentialing and Training

Each agency or entity providing disaster mental health personnel is responsible for validating the degree, licensure, training, and credentials of all staff they deploy to provide disaster mental health services and insure they meet any requirements of the requesting agency. For standardization purposes, Tennessee law (Title 24, Chapter 1, Part 2) on tort liability protection and privilege recognizes teams whose members have received disaster mental health training from one of the following entities; International Critical Incident Stress Foundation, American Red Cross, National Organization of Victims Assistance, Tennessee Public Safety Network, or other like agencies.

Activation Plan: Initial Response Phase (first two weeks)

The set up and administration of an Incident Command post for the event is the responsibility of emergency services agencies. A representative from ARC and the Regional Disaster Mental Health Response Committee may be asked to

have a presence in the Incident Command post or have an immediate contact point through the Liaison Officer. Access to the area where there is mental health need should be coordinated with permission of Incident Command. TEMA or local EMA will serve as the initial point of contact for all requests for disaster mental health services. Any community, agency, association and/or other entity may contact them to request disaster mental health services [*please reference Appendix B*]. TEMA will contact TDMH for assistance in responding to these requests. When warranted, ARC will deploy Disaster Mental Health Volunteers to impacted counties for the initial provision of disaster mental health services. In communication with ARC, the Regional Disaster Mental Health Committee may deploy Disaster Mental Health Response Teams to impacted counties for the provision of disaster mental health services. Disaster mental health services will have the capacity to provide:

Interdisciplinary Outreach Programs – ARC and/or Disaster Mental Health Response Teams will conduct outreach to interact with survivors in community sites where they are living, working, and reconstructing their lives. These teams may be assigned to work with inter-professional teams that perform multiple services in disaster areas.

Information & Referral Services - During times of disaster, victims can receive information concerning community resources and available assistance.

Telephone Support Counseling – During times of disaster a phone support service for those in the community affected by the disaster event will be available for a brief period. This service will be carried out by the resources of a Disaster Mental Health Response Team.

Psychological First Aid (PFA) – PFA is an evidence-informed modular approach to help survivors and/or emergency response personnel in the immediate aftermath of a critical incident/traumatic event. It is designed to reduce to initial distress caused by these events and to foster short and long term adaptive functioning and coping. PFA is designed for delivery in diverse settings such as general population shelters, special needs shelters, field hospitals/medical triage areas, acute care facilities, staging area/respite centers for first responders/relief workers, emergency operations centers, feeding locations, disaster assistance service centers, family reception centers, homes, businesses, and other community settings.

Basic objectives of PFA are:	Establish a human connection in a non-intrusive, compassionate manner Enhance immediate and ongoing safety, and provide physical and emotional comfort Calm and orient emotionally overwhelmed or distraught survivors Help survivors to tell you specifically what their immediate needs and concerns are, and gather additional information as appropriate Offer practical assistance and information to help survivors address their immediate needs and concerns Connect survivors as soon as possible to social support networks, including family members, friends, neighbors, and community helping resources Support adaptive functioning, acknowledge coping efforts and strengths, and empower survivors Provide information that may help survivors cope effectively with the psychological impact of disasters Be clear about disaster mental health availability, and when appropriate link the survivor to longer term resources
Core Actions of PFA are:	**Contact and Engagement –** respond to contact initiated by survivors, or to initiate contacts in a non-intrusive, compassionate, and helpful manner **Safety and Comfort –** enhance immediate and ongoing safety, and provide physical and emotional comfort **Stabilization –** calm and orient emotionally overwhelmed or disoriented survivors **Information Gathering: Current Needs and Concerns –** identify immediate needs and concerns, gather additional information, and tailor Psychological First Aid interventions **Practical Assistance –** offer practical help to survivors in addressing immediate needs and concerns

Connection with Social Supports – help establish brief or ongoing contacts with primary support person and other sources of support, including family members, friends, and community helping resources

Information on Coping – provide information about stress reactions and coping to reduce distress and promote adaptive functioning

Linkage with Collaborative Services – link survivors with available services needed at the time or in the future

Services to Populations with a Functional and Access Needs – Attention will be given to populations with a functional need such as the elderly, the chronically ill/mentally ill, non-English speaking populations, homeless, and those with physical or mental disabilities. Although no standard definition for "special needs" exists, there is a movement to move beyond using the category "special needs" to using a more effective, accurate description based on the functional needs of individuals. To say that someone has a "functional need" implies that he or she, under usual circumstances, is able to function on their own or with support systems. However during a disaster, their level of independence is challenged. The definition of someone with a functional need includes but is not limited to: chronic medical/psychiatric conditions, intellectual disabilities, substance abuse and individuals on Methadone treatments. This definition is an ongoing process, as the individuals and their needs, vulnerabilities and physical/mental health changes over time.

Each Regional Disaster Mental Health Committee should plan for individu

als with functional needs by:

Determine the Demographics of the Community. Define the functional needs populations who reside in the region.

Identify Key Contacts. Obtain names and contact information for direct service providers and advocacy organizations that work with functional needs individuals.

Facilitate Discussions. Find out the barriers and needs of individuals in the community. Invite applicable organizations/associations to participate in emergency planning.

Coordinate Outreach. Sponsor public information sessions on family and self-preparedness that includes a dialogue concerning the needs of individuals with functional needs.

Referral for Mental Health Counseling – Survivors and emergency service providers who need longer-term mental health counseling may require multiple sessions over a period of months to address their symptoms. ARC and Disaster Mental Health Response Teams shall refer such cases to local providers and may assist with making these referrals. These services lie within community mental health centers and private practitioners.

Media Consultation – A Public Information Officer (PIO) from ARC and a PIO from the Disaster Mental Health Response Team shall be available to the media as someone with expertise on the mental health impact of disasters. They will be available to assist the media in alleviating stress and conducting broad based community education and support during and following a disaster. This designated member will work with Incident Command's Public information Officer (PIO) around appropriate mental health messaging.

In most disasters the ARC will cease operations after approximately three to seven days. During the end of this two week period, ARC will work with the Disaster Mental Health Response Team(s) to transition out their personnel and turn over the provision of mental health services.

Spiritual Care – Spiritual Care includes anything that assists an individual, family or community in drawing upon their own spiritual perspective as a source of strength, hope and healing. In disaster, anything that nurtures the human spirit in coping with the crisis is considered Spiritual Care. Therefore, some of the basic standards and

principles of Disaster Spiritual Care include:

1. Offer presence and hospitality;
2. Meet, accept, and respect persons exactly as they are; and,
3. Do No Harm — never evangelize, proselytize or exploit persons in vulnerable need.

Intermediate Phase (14 days to 60 days post event)

If the event is a presidentially declared disaster, there could be a grant application submitted by TDMH for a FEMA-funded Crisis Counseling Assistance and Training Program (CCP), Immediate Services Program (ISP). Data regarding the services provided and the existing unmet need must be collected. This information is collected by ARC and the Disaster Mental Health Response Team(s) and forwarded to TDMH for the grant application. If a CCP ISP is funded, TDMH will contract with local community mental health centers for the provision of and continuation of disaster mental health services for a period of up to 60 days.

The CCP consists of services focused on preventing or mitigating adverse repercussions of a disaster. This goal is achieved through the use of a prevention and public health approach. Beginning with the most severely affected group and moving outward, the program seeks to serve a large portion of the population affected by the disaster. Program services are community based and often are performed in survivor's homes, shelters, temporary living sites, and churches. CCP services include supportive crisis counseling, education, development of coping skills, and linkage to appropriate resources, while assessing and referring those members of the community who are in need of more intensive mental health and substance abuse treatment to appropriate community resources. The CCP engages community gatekeepers and organizations through direct contact with stakeholder groups, such as unmet-needs committees, and participation in community events in order to facilitate response activities and services to survivors. The CCP is designed to assist with community recovery and collaboration in order to transition from CCP services to existing community resources upon the phase down of the program.

The CCP Model

The CCP is designed to provide immediate behavioral health support, primarily relying on face-to-face contacts with survivors in their communities. The CCP provides these support-centered services to survivors over a specific period of time. Eight key principles guide the CCP approach.

CCP services can be described as follows:

Strengths based: Crisis counselors assume natural resilience in individuals and communities, and promote independence rather than dependence on the CCP, other people, or organizations. Crisis counselors help survivors regain a sense of control.

Outreach oriented: Crisis counselors take services into the communities rather than wait for survivors to seek them.

More practical than psychological in nature: Crisis counseling is designed to prevent or mitigate adverse repercussions of disasters rather than to treat them. Crisis counselors provide support and education, listen to survivors, and accept the content at face value. Crisis counselors help survivors to develop a plan to address self-identified needs and suggest connections with other individuals or organizations that can assist them.

Diagnosis free: Crisis counselors do not classify, label, or diagnose people; they keep no records or case files. The CCP does not provide mental health or substance abuse treatment, or critical incident stress debriefing. Services are supportive and educational in nature.

Conducted in nontraditional settings: Crisis counselors make contact with survivors in their homes and communities, not in clinical or office settings.

Culturally competent: Crisis counselors strive to understand and respect the community and the cultures within it, and to demonstrate positive regard when interacting with survivors.

Designed to strengthen existing community support systems: Crisis counselors support, but do not organize or manage, community recovery activities. Likewise, the CCP supplements, but does not supplant or replace, existing community systems.

Provided in ways that promote a consistent program identity: Crisis counselors should work together early to establish a unified identity. The CCP strives to be a single, easily identifiable program, even though it may be carried out by a number of different local provider agencies.

CCP Primary and Secondary Services

There are two types of CCP services—primary and secondary. Primary CCP services are higher in intensity as they involve personal contact with individuals, families, or groups. Secondary CCP services have a broader reach and less intensity since they may be provided through written or electronic media. Examples of both are described below.

Primary CCP Services

Individual Crisis Counseling

Individual crisis counseling involves a process of engagement lasting at least 15 minutes. Its focus is to help disaster survivors understand their reactions, review their options, and connect with other individuals and agencies that may assist them in improving their situations. Staff members who provide individual crisis counseling are active listeners who offer reassurance, practical assistance, psycho-education, and emotional support, and who teach behavioral techniques for coping with stress.

Brief Educational or Supportive Contact

Educational information or emotional support is provided to individuals or groups, and typically is less than 15 minutes in duration. CCP staff members who provide brief educational or supportive contact are helpful educators and active listeners. They offer general support and provide general information, typically on resources and services available to disaster survivors. During this type of intervention, crisis counselors do not usually engage in in-depth discussion as they would during individual crisis counseling or psycho-education.

Group Crisis Counseling

Group crisis counseling occurs when disaster survivors and community members are brought together to meet for longer than 15 minutes. The group is led by a trained crisis counselor. The structure and format of group crisis counseling may vary, but group members should have similar levels of exposure to the disaster. Groups may be supportive or psycho-educational in nature. CCP crisis counselors who facilitate this service encourage the group members to do most of the talking, and they offer skills to help the group members cope with their situations and reactions. Throughout the process, the counselors assist group members with referrals to services often needed.

In addition to psycho-education or support groups, the CCP also may promote the development of self-help groups. CCP-initiated self-help groups should be facilitated by a professional or paraprofessional crisis counselor. The group can work toward autonomy by inviting a member to be a cofacilitator. Initially, the crisis counselor may be the primary leader of the group. Later, the group may continue without the presence of a professional or paraprofessional counselor, and be led by one or more of the group members. When group members are responsible for their own group process without the benefit of the presence of a professional or paraprofessional (a self-help support group), the group can no longer be considered a CCP effort, since the quality of the group process cannot be guaranteed and lacks reporting or accountability mechanisms.

Public Education

CCP outreach staff provide survivors with information and education about typical reactions, helpful coping strategies, and available disaster related resources. CCP staff members commonly provide this service through public speaking at community forums, professional in-service meetings, and local government meetings. In contrast to the group crisis counselor, the CCP staff member who conducts public education does most of the talking. The need for public educational services is likely to increase throughout the course of the CCP.

Assessment, Referral, and Resource Linkage

Crisis counselors are trained to assess an individual's or family's need for referral to additional disaster relief services or mental health or substance abuse treatment. Crisis counselors refer survivors experiencing severe reactions to the appropriate level of care. Survivors also may be referred to other disaster relief resources to meet a wide range of physical, structural, or economic needs. The crisis counselors who provide assessment and referral services need to be knowledgeable about local resources and work diligently to engage community organizations.

Community Networking and Support

Crisis counselors build relationships with community resource organizations, faith-based groups, and local agencies. They often attend community events to provide a compassionate presence and to be available to provide crisis counseling services, when needed. They may initiate or attend unmet-needs committee or long-term recovery meetings, or other disaster relief-oriented gatherings. It is important to note that communities, families, and survivors should "own" their community events. Crisis counseling staff can provide useful consultation during the planning process and valuable information and services at these events to demonstrate their support for members of the community.

Secondary CCP Services

Development and Distribution of Educational Materials

Flyers, brochures, tip sheets, educational materials, or Web site information is developed and distributed by the CCP workers to educate survivors and the community. Topics include basic disaster information, typical reactions to disaster, coping skills, and individual and community recovery and resilience. Materials that address the needs of at-risk populations, as well as materials developed in multiple languages, should be available. Materials may be handed out or left in public places, published in local newspapers, or mailed to survivors in areas most affected by a disaster. Examples of these materials can be obtained from SAMHSA DTAC.

Media and Public Service Announcements

CCP staff engage in media activities and public messaging in partnership with local media outlets, State and local governments, charitable organizations, or other community brokers of information. Media activities and messaging are designed to reach a large number of people in order to promote access to CCP services, and educate survivors and the community about disaster, disaster reactions and coping skills, and individual or community recovery and resilience. Venues for this messaging vary and may include media interviews with CCP spokespeople, television or radio public service announcements, use of Web sites or e-mail, or advertising.

Long Term Recovery (3 months to 12 months post event)

If there is evidence of continued need in a county or counties beyond 60 days post event, TDMH will apply for a FEMA-funded CCP, Regular Services Program (RSP) which can continue the provision of disaster mental health services for an additional 9 months post event to the anniversary of the event. Disaster mental health services provided through an RSP mirror those of the ISP, which are described in the "Intermediate Phase" section above.

Post Disaster Evaluation Process

After Action Review

Within four weeks of the conclusion of a large disaster mental health response, an after action review with the State Disaster Mental Health Committee and all applicable Regional Disaster Mental Health Committees will occur. It is the responsibility of the Chair of the State Committee to convene this group in a central location and if need be may occur by phone. Within four weeks of the conclusion of a small disaster mental health response, an after action review will be submitted by the Regional Disaster Mental Health Committee to the State Disaster Mental Health Committee. It is the responsibility of the Chair of the State Committee to insure these after action reviews are shared with other Regional Disaster Mental Health Committees as a learning tool.

Revision and Update of Plan

The State Disaster Mental Health Committee will review and update this plan on an annual basis. Any significant modification(s) may be made to the plan after an after action review.

Ethical and Legal Issues

Ethics

Anyone providing disaster mental health services must comply with the ethical and practice standards of their respective professional codes and act within the scope of their professional expertise.

Tort Liability/Testimonial Privilege

Disaster Mental Health Response Team members will be covered under professional liability malpractice insurance of their respective agencies. Tennessee law protects trained, members of a Disaster Mental Health Response Team with tort liability protection and privilege.

Dispensing of Medication

During times of disaster, survivors may have difficulty accessing needed medications for both physical and mental health conditions. To address this need, pursuant to Tennessee Code Annotated 63-10-207, a pharmacist may dispense to a patient up to a three (3) day supply of medication, which could include medications for the treatment of mental health illness. The law is as follows:

TCA 63-10-207 **Dispensing of medication prior to authorization.**

(a) Notwithstanding any provision of law to the contrary, a pharmacist may, in good faith, dispense to a patient without proper authorization the number of dosages of a prescription drug necessary to allow such patient to secure such authorization from such patient's prescriber, not to exceed a seventy-two-hour supply, if:
(b) The patient offers satisfactory evidence to the pharmacist that the prescriber has placed the patient on a maintenance medication and that such patient is with valid refills or for some valid reason cannot obtain proper authorization; and
(c) In the judgment of the pharmacist, the health, safety and welfare of the patient would be otherwise endangered.

Financial Issues

Pro Bono Services

Agencies deploying their Disaster Mental Health Response Teams are volunteering their professional services and as such, billing for any services provided at the scene is improper. These agencies will assume a pro-active advocacy role to ensure equitable reimbursement for follow-up services should money become available through grants.

Crisis Counseling Immediate Service Program Grant

In a presidentially declared disaster, a Crisis Counseling Immediate Services Program (ISP) grant from FEMA can assist in funding disaster mental health services in the first 60 days post event. However, it may take several weeks after a disaster for the grant to be approved. TDMH will contract with local community mental health centers for an ISP.

Crisis Counseling Regular Service Program Grant

In a presidentially declared disaster, a Crisis Counseling Regular Services Program (RSP) grant from FEMA can assist in funding disaster mental health services 9 months post ISP. TDMH will contract with local community mental health centers for a RSP.

Appendices

A ..... Acronyms

B ..... Activation Plan Flow Chart

C ..... National Voluntary Organizations active in Disaster Points of Consensus

D ..... Directory of TEMA Regional Staff

E ..... Directory of East Tennessee Local Emergency Management – Civil Defense Organizations – Directors Only

F ..... Directory of Middle Tennessee Local Emergency Management – Civil Defense Organizations– Directors Only

G ..... Directory of West Tennessee Local Emergency Management – Civil Defense Organizations– Directors Only

Appendix A

Acronyms

ARC ..... American Red Cross

CCP ..... Crisis Counseling Assistance and Training Program

CMHC ..... Community Mental Health Crisis Services

DTAC ..... Disaster Technical Assistance Center

EMA ..... Emergency Management Agency

EOC ..... Emergency Operations Center

ESF ..... Emergency Support Function

FEMA ..... Federal Emergency Management Agency

ISP ..... Crisis Counseling Immediate Services Program

PFA ..... Psychological First Aid

PHEP ..... Public Health Emergency Response

PIO ..... Public information Officer

RSP ..... Crisis Counseling Regular Services Program

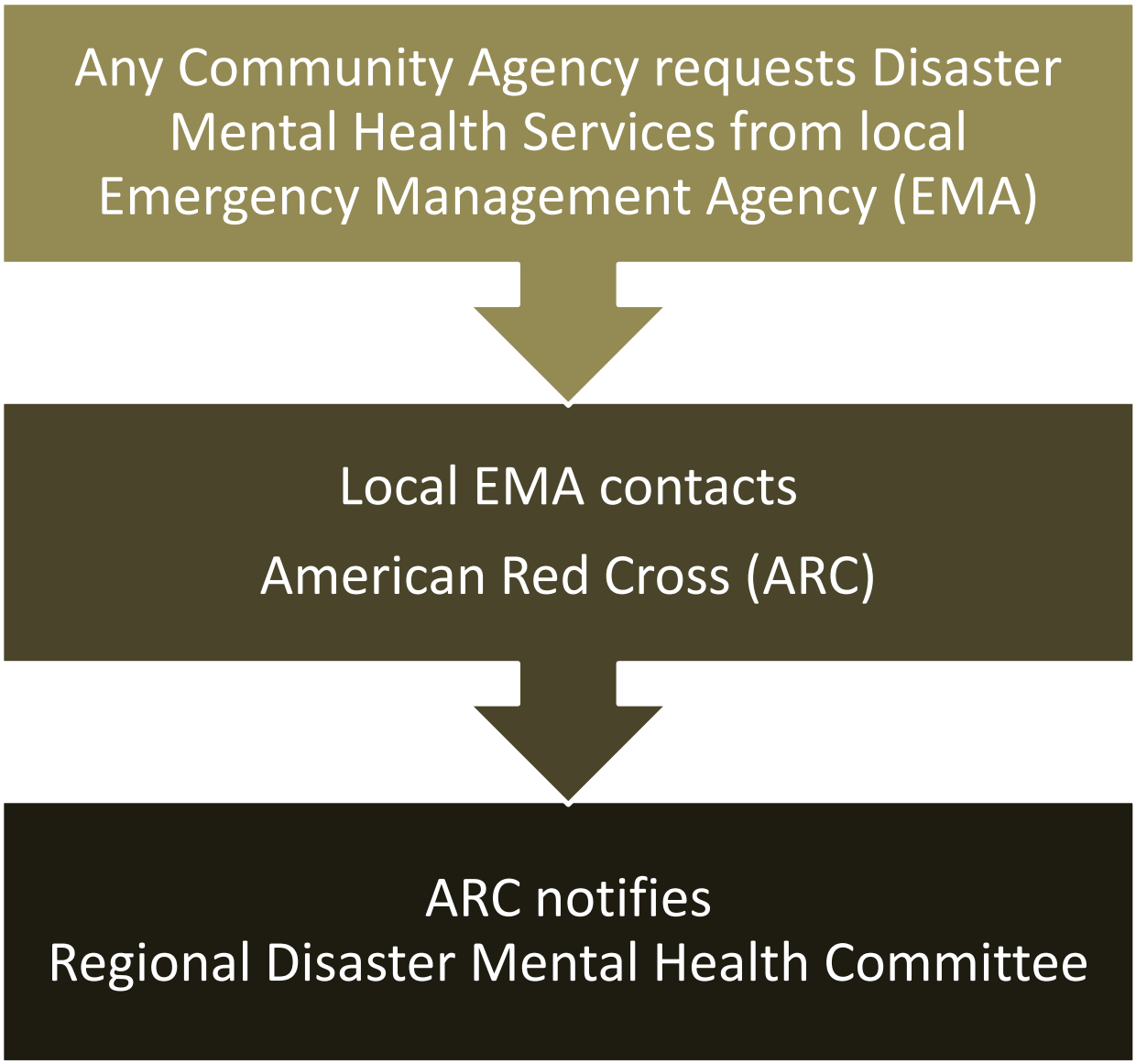
SAMHSA .... Substance Abuse and Mental Health Services Administration

TDH ..... Tennessee Department of Health

TDMH ..... Tennessee Department of Mental Health

TEMA ..... Tennessee Emergency Management Agency

Appendix B



NOTE:

Individual variations may be needed in this flow chart to address local needs.

Appendix C

Ratified by Full Membership, 2009

National Voluntary Organizations Active in Disaster
Points of Consensus

Disaster Spiritual Care

In 2006 the National Voluntary Organizations Active in Disaster's Emotional and Spiritual Care Committee published Light Our Way to inform, encourage and affirm those who respond to disasters and to encourage standards insuring those affected by disaster receive appropriate and respectful spiritual care services. As a natural next step following the publication of Light Our Way and in the spirit of the NVOAD "Four C's" (cooperation, communication, coordination and collaboration), the Emotional and Spiritual Care Committee then began working to define more specific standards for disaster spiritual care providers. The following ten "points of consensus" set a foundation for that continuing work.

1. **Basic concepts of disaster spiritual care**[1]
   Spirituality is an essential part of humanity. Disaster significantly disrupts people's spiritual lives. Nurturing people's spiritual needs contributes to holistic healing. Every person can benefit from spiritual care in time of disaster.

2. **Types of disaster spiritual care**[2]
   Spiritual care in disaster includes many kinds of caring gestures. Spiritual care providers are from diverse backgrounds. Adherence to common standards and principles in spiritual care ensures that this service is delivered and received appropriately.

3. **Local community resources**
   As an integral part of the pre-disaster community, local spiritual care providers and communities of faith are primary resources for post-disaster spiritual care. Because local communities of faith are uniquely equipped to provide healing care, any spiritual care services entering from outside of the community support but do not substitute for local efforts. The principles of the National VOAD - cooperation, coordination, communication and collaboration - are essential to the delivery of disaster spiritual care.

4. **Disaster emotional care and its relationship to disaster spiritual care**[3]
   Spiritual care providers partner with mental health professionals in caring for communities in disaster. Spiritual and emotional care share some similarities but are distinct healing modalities. Spiritual care providers can be an important asset in referring individuals to receive care for their mental health and vice versa.

5. **Disaster spiritual care in response and recovery**[4]
   Spiritual care has an important role in all phases of a disaster, including short-term response through long-term recovery. Assessing and providing for the spiritual needs of individuals, families, and communities can kindle important capacities of hope and resilience. Specific strategies for spiritual care during the various phases can bolster these strengths.

[1] See Light Our Way pp. 52-54. [2] Ibid. [3] Ibid. [4] Ibid.

Ratified by Full Membership, 2009

6. **Disaster emotional and spiritual care for the care giver**
   Providing spiritual care in disaster can be an overwhelming experience. The burdens of caring for others in this context can lead to compassion fatigue. Understanding important strategies for self-care is essential for spiritual care providers. Disaster response agencies have a responsibility to model healthy work and life habits to care for their own staff in time of disaster.[5] Post-care processes for spiritual and emotional care providers are essential.

7. **Planning, preparedness, training and mitigation as spiritual care components**[6]
   Faith community leaders have an important role in planning and mitigation efforts. By preparing their congregations and themselves for disaster they contribute toward building resilient communities. Training for the role of disaster spiritual care provider is essential before disaster strikes.

8. **Disaster spiritual care in diversity**
   Respect is foundational to disaster spiritual care. Spiritual care providers demonstrate respect for diverse cultural and religious values by recognizing the right of each faith group and individual to hold to their existing values and traditions. Spiritual care providers:
   - refrain from manipulation, disrespect or exploitation of those impacted by disaster and trauma.
   - respect the freedom from unwanted gifts of religious literature or symbols, evangelistic and sermonizing speech, and/or forced acceptance of specific moral values and traditions.[7]
   - respect diversity and differences, including but not limited to culture, gender, age, sexual orientation, spiritual/religious practices and disability.

9. **Disaster, trauma and vulnerability**
   People impacted by disaster and trauma are vulnerable. There is an imbalance of power between disaster responders and those receiving care. To avoid exploiting that imbalance, spiritual care providers refrain from using their position, influence, knowledge or professional affiliation for unfair advantage or for personal, organizational or agency gain.

   Disaster response will not be used to further a particular political or religious perspective or cause – response will be carried out according to the need of individuals, families and communities. The promise, delivery, or distribution of assistance will not be tied to the embracing or acceptance of a particular political or religious creed.[8]

10. **Ethics and Standards of Care**
    NVOAD members affirm the importance of cooperative standards of care and agreed ethics. Adherence to common standards and principles in spiritual care ensures that this service is delivered and received appropriately. Minimally, any guidelines developed for spiritual care in times of disaster should clearly articulate the above consensus points in addition to the following:
    - Standards for personal and professional integrity
    - Accountability structures regarding the behavior of individuals and groups
    - Concern for honoring confidentiality*
    - Description of professional boundaries that guarantee safety of clients* including standards regarding interaction with children, youth and vulnerable adults
    - Policies regarding criminal background checks for service providers
    - Mechanisms for ensuring that caregivers function at levels appropriate to their training and educational backgrounds*
    - Strong adherence to standards rejecting violence against particular groups
    - Policies when encountering persons needing referral to other agencies or services
    - Guidelines regarding financial remuneration for services provided

[5] Ibid. [6] Ibid. [7] Church World Service "Standard of Care for Disaster Spiritual Care Ministries" [8] Church World Service "Common Standards and Principles for Disaster Response" *See Light Our Way p. 16

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